

Addressing the Health and Safety of Children in Foster Care

by the Rees-Jones Center for Foster Care Excellence at Children's Medical Center

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The Texas foster care system is an integral part of the safety net for the state's most vulnerable children, and is charged with the daunting task of providing safe homes to thousands of children who are in crisis. Systemic deficiencies remain in the foster care system despite numerous initiatives developed to address the challenges. Children and youth in foster care still face persistent barriers when they interact with the health system, which blunt the effectiveness of reform initiatives and potentially create lifelong harms for children in the program. Addressing disparities in the areas of physical health, mental health, educational attainment and special health care needs is integral to improving safety, stability and permanency for every child across the foster care system.

The Rees-Jones Center for Foster Care Excellence at Children's Medical Center applauds the hardworking men and women who dedicate their lives, careers and homes to make life better for children in the state's foster care system. Texas is fortunate to have a robust infrastructure that includes dedicated families, Child Protective Service (CPS) staff and leaders within Department of Family Protective Services (DFPS), STAR Health, concerned judges and attorneys, and court advocates and volunteers.

Despite these advantages, it is clear after serving thousands of children in foster care at the Rees-Jones Center that **perpetual systemic gaps are creating alarming clinical patterns, such as preventable health declines, non-medical hospitalizations and moves from home to home, putting at risk the most vulnerable children in Texas.** It should bring some hope, then, that almost every concerning pattern and challenge we observe is avoidable by adopting systemic reforms that target health care delivery.

The information presented below is based on the extensive experiences of the Rees-Jones Center's clinical care teams, who together serve more than 1,350 children in foster care each year. While these experiences are drawn from one Center, our facility serves children from across Texas; thus, we believe the observations are indicative of broader statewide challenges and opportunities. **This paper outlines a series of recommendations in the areas of quality, infrastructure, integration, caregiver support, and safety that, if taken together, can significantly improve health outcomes, well-being, and successful permanency that will make Texas foster care a model for the nation.**

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About Texas Foster Care

- More than **47,000** children were in DFPS custody during state fiscal year (FY) 2015, which includes all children under age 18 for whom DFPS has legal custody, regardless of their placement, and youth who have aged out of DFPS legal responsibility but remain in substitute care.¹
- **31,200** of these children lived in a verified foster care placement at some point during 2015. Of these, **7,305** live in DFPS Region 3, the largest region in the state, which encompasses a 19-county area in north central Texas (including Dallas, Tarrant, Collin and Denton Counties).
- The vast majority of children enter foster care due to abuse or neglect.
- Of all children in DFPS custody, approximately one in eight (5,900 children) are considered to be “high needs children,” meaning they have special medical, behavioral or emotional indicators, or are in the IDD (intellectual and developmental disabilities) population.²
- National studies indicate that up to 80 percent of children in foster care have at least one chronic medical condition, while 25 percent have three or more chronic conditions.³

Concerns About Health Care Access

Access to timely and effective pediatric and mental health care is particularly critical for children in foster care given the growing body of science documenting the short and long-term impacts of abuse and neglect on the developing brain, immune system, disease potential and adult health and behavioral outcomes.⁴

Children routinely come to the Center experiencing physical distress, missed diagnoses, overlooked symptoms, and missing prescribed medications and medical equipment. These observations are consistent regardless of a child’s living arrangement, county or region of residence or length of time in care. They range from individuals with readily treatable conditions such as asthma, anxiety or developmental delays, to complex conditions such as traumatic brain injury or serious mental illness. These disparities are often the result of inadequate health assessments, transition planning and monitoring as children enter, move through, and exit foster care — and they occur despite universal health insurance coverage, current policies and a strong advocacy community. In fact, every child in the Texas foster care system has health care coverage through Texas’ STAR Health program, which provides Medicaid and other benefits from entry through exit from foster care.

These gaps result in chronically unmet health care needs that affect children’s ability to function at their full potential, creating lifelong disadvantages. **We observe a series of concerning patterns, including worsening disease status, declines in mental and behavioral health, unnecessary and prolonged hospitalizations, unsafe foster care transitions, placement disruptions, adoption dissolutions, and poor educational outcomes.** These observations hold true regardless of the child’s level or type of medical or mental health complexity.

We believe these health disparities can be markedly reduced by following the recommendations outlined below.

The Center has conducted more than 200 case reviews with local and regional CPS leaders since 2010. We consistently find that CPS staff, health care providers and courts almost always uniformly follow existing policies and used resources to the best of their knowledge. **Thus, we are convinced current health care requirements within Texas Health Steps, Medicaid and DFPS policies do not include necessary safeguards to address the high rate of trauma, transition, co-morbid physical and mental health conditions, and chronic conditions among children in foster care.**

The American Academy of Pediatrics (AAP) has endorsed 24 health supervision standards for children in foster care.⁵ According to a new report by the Texas Pediatric Society’s Foster Care Committee, Texas completely meets only one of the 24 standards, and partially aligns with only eight.⁶ Aligning Texas state policies with the AAP standards would standardize how children are assessed, treated and monitored. This will greatly improve trauma-informed care, child abuse recovery, mental health supports and overall child health.

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Recommendations

The Rees-Jones Center for Foster Care Excellence recommends the following policy changes. We believe that these steps, taken together, will significantly improve the Texas foster care system — for children, caregivers, parents, and the agencies and advocates serving them.

Enhance Health Care Quality Standards

1. Implement community-based and hospital-based health care standards for children in foster care from entry through permanency that are distinct and enhanced from traditional Medicaid or Texas Health Steps (THSteps) requirements, and are consistent with principles included in the AAP standards. State standards should include:
 - Adoption of an enhanced THSteps visit schedule, beginning with an immediate pediatric health assessment upon entering foster care. To support CPS workers in the field who identify abused and neglected children entering foster care, the state could adopt an immediate technology-supported field health triage, followed by an appropriately-timed in-person health assessment by a STAR Health provider within a few days of entering care.
 - Expansion of THSteps requirements to include trauma-informed components including specific monitoring of trauma symptoms, caregiver needs, child developmental, mental health symptoms, normalcy, disabilities, infectious disease and emerging chronic conditions.
 - Requirements should also address access to health care and reassessments after planned and unplanned transitions. These expansions help children and families avoid delays and interruptions in health care, reduce placement disruptions and unnecessary hospitalizations, as well as avoid declines in health as children move from family to family to permanency.
2. Enhance statewide standards for health care transition planning including caregiver preparation, continuity of health care, safe and necessary transportation and CPS-healthcare communication when children experience any disruption or change in residence, including discharge from hospital or residential treatment settings.
 - Primary medical needs staffing calls (PMN) do not require participation by the child’s current treating hospital-based or community-based health care/medical providers. Lack of health care provider participation contributes to miscommunication, delays effective planning, delays identification of foster homes, and contributes to poor transition planning.
 - Currently, no policy standardizes medical assessment of the child’s comfort, cardiopulmonary status, and pain control during long-distance medical transport.

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3. Consider the incorporation of telemedicine and telemonitoring to supplement the face-to-face and in-person care that children in foster care receive, particularly for children with complex medical and mental health conditions that would benefit from active monitoring.

Ensure Safety and Reporting

4. Children should receive a comprehensive reassessment upon each placement disruption and findings should be recorded and any corrections to the health record made. Placement disruptions — including adoption dissolutions — are not reviewed to identify contributing factors. Often, disruptions are due to untreated or undertreated medical or behavioral health problems.
5. Establish one telephone number for concerns from health care providers, schools and others regarding children in foster care. The “warmline” would enable easier contact with CPS, as well as earlier reporting of concerns with caregiving, neglect, transitions or problems with access to care.
6. Create a separate Residential Child Care Licensing (RCCL) hotline, investigation and communication process for children in foster care. Components should include sharing of past investigation outcomes with each CPS worker involved with a child in the home. The system should include a trauma-informed health assessment of every child’s safety and health status in consultation with health care providers when a report involves a home with children with special health care needs.

Expand Infrastructure to Support Child Protection/Health Care Collaboration

7. Assign a nurse coordinator to each child from entry to permanency to assist with regular monitoring of unmet health needs, updating active health histories, responding to health declines or delays in care, reaching out to treatment teams, communicating complete and relevant health histories with court teams during hearings and permanency decisions, and training and supporting caregivers.
8. Create regional medical and mental health consult teams to provide health consultation to CPS, Child Placing Agencies, hospitals and court teams when there are questions or concerns regarding a child’s health status, quality of care and healthcare needs, particularly for children with complex medical needs or comorbid medical and mental health conditions.

9. Establish non-punitive, protected, regional foster care quality improvement boards or entities linked to a state quality improvement process. The process would allow forums to review concerning cases with root causes analysis to identify training needs, identify local versus statewide trends and contribute to early, targeted practice and policy improvements, when necessary. Current review processes exclude health care professionals serving children.
10. Establish an accessible, secure electronic child welfare-medical record with real-time information across all parties who have legal access to health information including a child's trauma history, strengths, health status, active health issues, unmet medical needs, treatment plans and recommendations. This lack of information risks duplication of painful and costly procedures, delays in care, and declines in physical health, mental health and educational attainment.
 - Currently, key health histories — newborn screens, immunization records, active diagnoses and treatment plans, hospital discharge summaries, and laboratory results — require extensive researching, which is time prohibitive and costly.
 - Often, psychological assessments are not shared by psychologists due to legal constraints which delays access to necessary behavioral and educational services.
11. The federally-required health care oversight committee under Fostering Connections should include individuals and entities representing each region, and be led by state officials.

Integrate Health Care Professionals into Decision Making

12. Consult licensed medical and mental health professionals and include them when child welfare and courts make decisions that affect a child's treatment options for medical, mental, developmental or other health issues.
 - CPS, foster parents, Court Appointed Special Advocates, judges, and attorneys do not have access to health consultation/medical expertise to interpret health information when assessing current health status, adequacy of health care services, adequacy of caregiving, as well as when making decisions to restrict or require health care services.
 - CPS and courts identify new caregivers without uniform standards to safely assess a family's readiness to meet the child's emotional or physical health issues or ability to secure necessary health care supports, including medications and equipment. Lack of uniformity contributes to placement disruptions when caregivers are ill-prepared for known medical and mental health diagnoses.

13. Court-ordered health care treatment or restrictions of health care treatment should require consultation with licensed medical and mental health professionals and include a report of the child's health status from the child's health care provider.

Improve Caregiver Education & Support

14. Provide foster families with full, necessary in-home assistance to support children with developmental disabilities, complex medical conditions, and mental health conditions to help ensure permanency and child well-being. Adequate in-home supports can help improve health and mental health outcomes, avoid disrupted placements, hospitalizations, non-medical hospital stays and poor health outcomes.
15. Reconfigure hospital discharge planning to ensure new caregivers are formally assessed for reasonable knowledge, skills and parenting behaviors needed to safely care for a child with special health care needs, including those with complex medical and mental needs. Currently, Child Placing Agencies and CPS do not require that new caregivers meet a hospitalized child in person prior to discharge — both when caregivers live in town or out of town — unless a child has a tracheostomy.
16. Consider a uniform reimbursement model that promotes caregiver training and education at a child's bedside. Current policy does not establish a caregiver payment structure until a child arrives in a foster home, creating a barrier to early education and training.
17. Allow families caring for neurologically-devastated or profoundly disabled children regular in-home respite to increase placement options, avoid disruptions and promote permanency.
18. Implement pre-placement assessment standards to determine caregiver capacity and support to meet a child's health and mental health treatment needs with consideration of caregiver experience, number of children and level of complexity of other children residing in the potential home.

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Conclusion

The institutional and systemic challenges outlined in this paper require state-level action to truly improve the health and safety of children in foster care. Regional, local and provider efforts are creating pockets of success drawn from local strengths and capacities that provide ideas for a statewide model; yet without state-level support, these efforts will fall short of the broad-based institutional changes that are required. While the observed disparities among the foster care population are troubling, the Rees-Jones Center staff believe the solutions are achievable and within our capacity to deliver.

ABOUT THE REES-JONES CENTER FOR FOSTER CARE EXCELLENCE

The Rees-Jones Center for Foster Care Excellence at Children's Medical Center is a partnership between the Children's Health System of Texas and the University of Texas Southwestern Medical Center. Thanks to a generous grant from the Rees-Jones Foundation in 2014, the Center transformed its 25 year foster care medical home program into a multifaceted Center with clinical, academic, and community development experts dedicated to improving the well-being and long-term outcomes of children and youth in Texas Foster Care. The Center is home to the only integrated foster care clinical program in North Texas. This innovative healthcare model brings together child welfare, pediatric, early childhood, and mental health professionals, as well as nurse coordination, to ensure every child receives rehabilitative and recovery-focused, community-based services that promote optimal health, mental health, educational attainment, permanency and long-term well-being.

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